

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:
01-020

2. STATE
Washington

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE
July 1, 2001

5. TYPE OF PLAN MATERIAL (Check One):

SEP 25 2001

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$ 163,803
b. FFY 2002 \$ 828,853

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A
Part I
Pages 1 through 34

Attachment 4.19-B, page 4-B (P+I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 4.19-A
~~Part II~~ **Part I (P+I)**
Pages 1 through 34

10. SUBJECT OF AMENDMENT:

Critical Access Hospital Program

11. GOVERNOR'S REVIEW (Check One):

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:
DENNIS BRADDOCK

14. TITLE:
Secretary

15. DATE SUBMITTED:

9/21/01

16. RETURN TO:

Department of Social and Health Services
Medical Assistance Administration
623 8th St SE MS: 45500
Olympia, WA 98504-5500

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

SEP 25 2001

18. DATE APPROVED:

DEC 13 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

JUL - 1 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

151

21. TYPED NAME:

TERESA L. TRIMBLE

22. TITLE:

**ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID AND STATE OF WASH.**

23. REMARKS:

P+I changes authorized by the state on 10/9/01.

**POSTED 9/21/01
(DATE)**

**Olympia
(CITY/STATE)**

P+I changes authorized by the state on 12/10/01.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING
PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES

The State has in place a public process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

METHODS AND STANDARDS FOR ESTABLISHING
PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES

A. INTRODUCTION

The State of Washington's Department of Social and Health Services (DSHS) implemented a Diagnosis Related Groups (DRG) based reimbursement system for payment of inpatient hospital services to Medicaid clients in the mid 1980's. This system as revised through this amendment, is used to reimburse for admissions on or after January 1, 2001. Revisions to this system are made as necessary through amendments to the State plan.

The standards used to determine payment rates take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs. The system includes payment methods to hospitals for sub-acute care, such as skilled nursing and intermediate care, and payment methods for lower levels of acute care such as Long Term Acute Care (LTAC), and Level B Inpatient Acute Physical Medicine and Rehabilitation (PM&R) care. The rates for these services are lower than those for standard inpatient acute care. This includes Level B PM&R care provided by skilled nursing facilities acting as Level B PM&R centers.

The reimbursement system employs three major methods to determine hospital payment rates: DRG cost-based rates; DRG contract rates; and rates based on hospitals' ratio of costs-to-charges (RCC). The DRG and RCC payment methods are augmented by trauma care payment methods at state-approved trauma centers. The trauma care enhancement is an increased percentage provided to the base Medicaid rate. The amount of trauma care enhancement varies contingent upon State legislative funding for the Department of Health's Trauma Program.

A fixed per diem payment method is used in conjunction with the Acute PM&R and LTAC programs. A cost settlement payment method is used to reimburse hospitals participating in the state's Title XIX Critical Access Hospital (CAH) program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

Contract hospitals participating in the federally waived Medicaid Selective Contracting Program are paid for services based on their contract bid price and/or an RCC method. Hospitals not located in contract areas and hospitals exempt from selective contracting are reimbursed on a cost-based DRG rate and/or an RCC method, or fixed per diem method.

Non-contract hospitals in selective contracting program areas provide emergency (including maternity) services, and other DRG exempt services such as AIDS related care. These hospitals are reimbursed on a cost-based DRG rate and/or under the RCC method.

Certain hospitals and services are exempt from the DRG payment methods, and are reimbursed under the RCC, cost settlement, or fixed per diem payment method.

The following plan specifies the methods and standards used to set these payment rates, including: definitions; general reimbursement policies; methods for establishing cost-based DRG rates; methods for establishing RCC payment rates; upper payment limits; and administrative policies on provider appeal procedures, uniform cost reporting requirements, audit requirements, public notification requirements.

B. DEFINITIONS

The terms used in this plan are intended to have their usual meanings unless specifically defined in this section or otherwise in the plan.

1. Accommodation and Ancillary Costs

Accommodation costs: the expense of providing such services as regular room, special care room, dietary and nursing services, medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

Ancillary costs: the expense of providing such services as laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including anesthesia and postoperative recovery rooms). Ancillary services may also include other special items and services.

2. Case-Mix Index (CMI)

Case-mix index means a measure of the costliness of cases treated by a hospital relative to the cost of the average of all Medicaid hospital cases, using DRG weights as a measure of relative cost.

3. Critical Access Hospital (CAH) Program

Critical Access Hospital (CAH) program means a Title XIX inpatient and outpatient hospital reimbursement program where hospitals meeting the Medicare qualifications for CAH designation are reimbursed through a cost settlement method.

4. DSHS

DSHS means the Department of Social and Health Services. DSHS is the State of Washington's state Medicaid agency.

5. Diagnosis Related Groups (DRGs)

DRG means the patient classification system originally developed for the federal Medicare program which classifies patients into groups based on the International Classification of Diseases, the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. The DRGs categorize patients into clinically coherent and homogenous groups with respect to resource use. The Washington State Medicaid program currently uses The All Patient Grouper and has established relative weights for 400 valid DRGs for its DRG payment system. There are an additional 168 DRGs that are not used and another 241 DRGs with no weights assigned. Of the 241 DRGs with no weights, two are used in identifying ungroupable claims under DRG 469 and 470. The remainder of the 241 DRGs are exempt from the DRG payment method. The All Patient Grouper, Version 14.1 has a total of 809 DRGs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

6. Emergency Services

Emergency services means services provided for care required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in: placing the client's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Inpatient maternity services are treated as emergency services.

7. HCFA

HCFA means the Department of Health and Human Services former Health Care Financing Administration (HCFA), renamed the Center for Medicare and Medicaid Services (CMS) in June 2001. CMS, formerly named HCFA, is the federal agency responsible for administering the Medicaid program.

8. Hospital

Hospital means a treatment facility which is licensed as an acute care hospital in accordance with applicable State laws and regulations, and which is certified under Title XVIII of the federal Social Security Act.

9. Inpatient Services

Inpatient services means all services provided directly or indirectly by the hospital subsequent to admission and prior to discharge of an inpatient, and includes, but is not limited to, the following services: bed and board; medical, nursing, surgical, pharmacy and dietary services; maternity services; psychiatric services; all diagnostic and therapeutic services required by the patient; the technical and/or professional components of certain services; use of hospital facilities, medical social services furnished by the hospital, and such drugs, supplies, appliances and equipment as required by the patient; transportation services subsequent to admission and prior to discharge; and, services provided by the hospital within 24 hours of the client's admission as an inpatient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

10. Long Term Acute Care

Long Term Acute Care (LTAC) means prior authorized inpatient services provided directly or indirectly by a State designated Long Term Acute Care hospital. LTAC services are authorized, subsequent to patient admission, but after the treatment costs in a DRG paid case have exceeded high-cost outlier status. At the point that determination is made the mode of care and reimbursement, if authorized by DSHS may switch to LTAC under a fixed per diem rate. This is not sub-acute care, rather this is intensive acute inpatient care provided to patients that would otherwise remain in intensive care or a similar level of care in or out of a hospital's intensive care unit.

The fixed per diem rate was based on an evaluation of patient claims costs for this type of patient and is updated annually through an inflation adjustment.

The LTAC services include, but are not limited, to: bed and board; services related to medical, nursing, surgical, and dietary needs; IV infusion therapy, prescription and nonprescription drugs, and/or pharmaceutical services and total parenteral nutrition (TPN) therapy, up to two hundred dollars per day in allowed charges; and medical social services furnished by the hospital.

11. MI/GAU

MI/GAU, as used in Paragraph F.2 and F.3 below, means the DSHS Limited Casualty Program-Medically Indigent (MI) or General Assistance Unemployable (GAU) services.

12. RCC

RCC means a hospital costs-to-charges ratio calculated using annual HCFA 2552 Medicare Cost Report data provided by the hospital. The RCC, not to exceed 100 percent, is calculated by dividing adjusted operating expense by adjusted patient revenues. The basic payment is established by multiplying the hospital's assigned RCC ratio (not to exceed 100 percent) by the allowed charges for medically necessary services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

13. Operating, Medical Education and Capital Costs

Costs are the Medicare-approved costs as reported on the HCFA 2552 and are divided into three components:

Operating costs include all expenses except capital and medical education incurred in providing accommodation and ancillary services; and,

Medical education costs are the expenses of a formally organized graduate medical education program; and,

Capital-related costs include: net adjusted depreciation expenses, lease and rentals for the use of depreciable assets, the costs for betterment and improvements, cost of minor equipment, insurance expenses on depreciable assets, interest expense and capital-related costs of related organizations that provide services to the hospital. Capital costs due solely to changes in ownership of the provider's capital assets on or after July 18, 1984, are deleted from the capital component.

14. Uninsured Indigent Patient

Means an individual who receives hospital inpatient and/or outpatient services and the cost of delivered services is not met because he/she has no or insufficient health insurance or other resources to cover the cost. The cost of services for uninsured indigent patients is identified through the hospital's charity and bad debt reporting system. Charity care and bad debt, is defined by the Department of Health through its hospital cost reporting regulations WAC 246-453-010, (4) "INDIGENT PERSONS" (Supplement 1 to Attachment 4.19-A, Part I, Pages 1 through 10) and RCW 70.170 "HEALTH DATA AND CHARITY CARE" (Supplement 2 to Attachment 4.19-A, Part I, Pages 1 through 11), means those patients who have exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below 200 percent of the federal poverty standards, adjusted for family size or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payor; (5) "Charity care" means appropriate hospital-based medical services provided to indigent persons, as defined in this section.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

Services covered by an insurance policy are not considered an uninsured covered service.

15. Cost Limit For DSH Payments

For the purpose of defining cost under the DSH program a ratio of cost to charge (RCC) is calculated on annual HCFA 2552 Medicare Cost data, per B.10. The RCC is applied to total hospital billed charges to arrive at the hospitals total cost.

16. DSH One Percent Medicaid Utilization Rate

All hospitals must meet the one percent Medicaid inpatient utilization in order to qualify for any of the DSHS disproportionate share programs.

17. DSH Limit

The DSH limit in Section B.15 is applicable for public hospitals. In accordance with the Omnibus Budget Reconciliation Act of 1993, the amounts paid under DSH programs to public hospitals will not exceed 100 percent of cost.

18. Trauma Centers

Trauma Centers are designated by the State of Washington Department of Health (DOH) into five levels, based on level of services available. This includes Level I, the highest level of trauma care, through Level V, the most basic trauma care. Level of designation is determined by specified numbers of health care professionals trained in specific trauma care specialties, inventories of specific trauma care equipment, on-call and response time minimum standards, quality assurance and improvement programs, and commitment level of the facility to providing trauma related prevention, education, training, and research services to their respective communities.

C. GENERAL REIMBURSEMENT POLICIES

The following section describes general policies governing the reimbursement system.

TN# 01-020 Approval Date: _____ Effective Date: 07/01/01
Supersedes
TN# 01-005

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

1. DRG Payments

Except where otherwise specified, DRG exempt hospitals, DRG exempt services and special agreements, payments to hospitals for inpatient services are made on a DRG payment basis. The basic payment is established by multiplying the assigned DRG's relative weight for that admission by the hospital's rate as determined under the method described in Section D. Any client responsibility (spend-down) or third party liability as identified on the billing invoice or by the Medical Assistance Administration (MAA) is deducted from the basic payment to determine the actual payment for that admission.

2. DRG Relative Weights

The reimbursement system uses Washington State, Medicaid-specific DRG relative weights. To the extent possible, the weights are based on Medical Assistance (Medicaid) claims for the period February 1, 1997 through December 31, 1998, and Version 14.1 of the Health Information Systems (HIS) DRG All Patient Grouper software. The relative weight calculations are based on Washington Medical Assistance claims and Washington State Department of Health's (CHARS) claims representative of Healthy Options managed care. Each DRG is statistically tested to assure that there is an adequate sample size to ensure that relative weights meet acceptable reliability and validity standards.

The relative weights are standardized to an overall case-mix index of 1.0 based on claims used during the recalibration process, but are not standardized to a case-mix index of 1.0 regarding the previous relative weights used.

3. DRG High-Cost Outlier Payments

High-cost outliers are cases with extraordinarily high costs when compared to other cases in the same DRG. The reimbursement system includes an outlier payment for these cases. To qualify as a DRG high-cost outlier, the allowed charges for the case must exceed a threshold of three times the applicable DRG payment or \$33,000, whichever is greater.

TN# 01-020 Approval Date: _____ Effective Date: 07/01/01
Supersedes
TN# 01-005

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

Reimbursement for outlier cases other than cases in children's hospitals (Children's Hospital and Medical Center, Mary Bridge Children's Hospital), and psychiatric DRGs, is the applicable DRG payment amount plus 75 percent of the hospital's RCC ratio applied to the allowed charges exceeding the outlier threshold. Reimbursement for DRG psychiatric (DRGs 424-432) outliers is at the DRG rate plus 100 percent of the hospital RCC ratio applied to the allowed charges exceeding the outlier threshold. Reimbursement for outlier cases at the state's two children's hospitals is the applicable DRG payment amount plus 85 percent of the hospital's RCC ratio applied to the allowed charges exceeding the outlier threshold.

4. DRG Low Cost Outlier Payments

Low cost outliers are cases with extraordinarily low costs when compared to other cases in the same DRG. To qualify as a DRG low cost outlier, the allowed charges for the case must be equal to or less than the greater of 10 percent of the applicable DRG payment or \$450. Reimbursement for these cases is the case's allowed charges multiplied by the hospital's RCC ratio.

5. DRG Long Stay Day Outlier Payments

Day Outlier payments are included only for long-stay clients, under the age of six, in disproportionate share hospitals and for children under age one in any hospital. (See C.15 Day Outlier payments).

6. RCC payments

Except where otherwise specified, hospitals and services exempt from the DRG payment method are reimbursed under the RCC method. The basic payment is established by multiplying the hospital's assigned RCC ratio (not to exceed 100 percent) by the allowed charges for medically necessary services. Recipient responsibility (spend-down) or third party liability as identified on the billing invoice or by DSHS is deducted from the basic payment to determine the actual payment for that admission.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

7. DRG Exempt Hospitals

The following hospitals are exempt from the DRG payment method for Medicaid.

a. Peer Group A Hospitals

Peer Group A hospitals, as defined in Section D.2.

b. Psychiatric Hospitals

Designated psychiatric facilities, state psychiatric hospitals, designated distinct part pediatric psychiatric units, and Medicare-certified distinct part psychiatric units in acute care hospitals are this type of facility. This currently includes, but is not limited to, Fairfax Hospital, Lourdes Counseling Center, West Seattle Psychiatric Hospital, the children's psychiatric unit at Sacred Heart Hospital, the psychiatric unit at Children's Hospital & Medical Center, and all other Medicare-certified and State approved distinct part psychiatric units doing business with the State of Washington.

c. Rehabilitation Units

Rehabilitation services provided in specifically identified rehabilitation hospitals and designated rehabilitation units of general hospitals. The criteria used to identify exempt hospitals and units are the same as those employed by the Medicare program to identify designated distinct part rehabilitation units. In addition, clients in the MAA Physical Medicine and Rehabilitation program (PM&R), who are not placed in a designated rehabilitation hospital or unit, are excluded from DRG payment methods. Prior authorization is required for placement into the rehabilitation unit.

d. Critical Access Hospital (CAHs)

Medicare designated CAHs receive Medicaid prospective payment based on Departmental Weighted Cost-to-Charge (DWCC). Post-period cost settlement is then performed.

TN# 01-020
Supersedes
TN# 01-005

Approval Date: _____ Effective Date: 07/01/01

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

e. Managed Health Care

Payments for clients who receive inpatient care through managed health care programs. If a client is not a member of the plan, reimbursement for admissions to managed health care program hospital will be determined in accordance with the applicable payment methods for contract or non-contract hospitals described in Section D, Section E and/or Section F.

f. Out-of-State Hospitals

Out-of-state hospitals are those facilities located outside of Washington and outside designated border areas as described in Section D. These hospitals are exempt from DRG payment methods, and are paid an RCC ratio based on the weighted average of RCC ratios for in-state hospitals.

g. Military Hospitals

Unless specific arrangements are made, Military hospitals are exempt from the DRG payment methods, and are reimbursed at their allowed charges.

8. DRG Exempt Services

a. Neonatal Services

DRGs 620 and 629 (normal newborns) are reimbursed by the DRG payment method. DRGs 602-619, 621-624, 626-628, 630, 635, 637-641 neonatal services are exempt from the DRG payment methods, and are reimbursed under the RCC payment method.

b. AIDS Related Services

AIDS related inpatient services are exempt from DRG payments methods, and are reimbursed under the RCC method for those cases with a reported diagnosis of Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) and other Human Immunodeficiency Virus (HIV) infections.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

c. Long-Term Care Services

Long-term care services are exempt from DRG payment methods. These services are reimbursed based on the statewide average Medicaid nursing home rate, adjusted for special staff and resource requirements. Hospitals must request a long-term care designation on a case-by-case basis.

d. Level B Inpatient Acute Physical Medicine and Rehabilitation Services

Level B Inpatient Acute Physical Medicine and Rehabilitation (PM&R) services are exempt from DRG payment methods. Level B PM&R services are reimbursed using a fixed per diem rate. The fixed per diem rate was based on an evaluation of patient claims costs for this type of patient and is updated annually through an inflation adjustment. Hospitals and skilled nursing facilities must request and receive a Level B PM&R designation. Care is authorized and provided on a case-by-case basis.

e. Bone Marrow And Other Major Organ Transplants

Services provided to clients receiving bone marrow transplants and other major organ transplants are exempt from the DRG payment method, and are reimbursed under the RCC method.

f. Chemically-Dependent Pregnant Women

Hospital-based intensive inpatient care for detoxification and medical stabilization provided to chemically-dependent pregnant women by a certified hospital are exempt from the DRG payment method, and are reimbursed under the RCC payment method.

g. Long Term Acute Care Program Services

Long Term Acute Care (LTAC) services are exempt from DRG payment methods. LTAC services are reimbursed using a fixed per diem rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

The fixed per diem rate was based on an evaluation of patient claims costs for this type of patient and is updated annually through an inflation adjustment. Hospitals must request and receive a LTAC designation. Care is authorized and provided on a case-by-case basis.

- h. Services Provided in DRGs that do not have a Medical Assistance Administration relative weight assigned.

Services Provided in DRGs that do not have a Medical Assistance Administration relative weight assigned are reimbursed using the RCC payment method.

- i. Trauma Center Services

Trauma Centers are designated by the State of Washington Department of Health (DOH) into five levels, based on level of services available. This includes Level I, the highest level of trauma care, through Level V, the most basic trauma care. Level of designation is determined by specified numbers of health care professionals trained in specific trauma care specialties, inventories of specific trauma care equipment, on-call and response time minimum standards, quality assurance and improvement programs, and commitment level of the facility to providing trauma related prevention, education, training, and research services to their respective communities.

Trauma centers services are reimbursed using an enhanced payment based on the trauma care fund established by the State of Washington in 1997 to improve the compensation to physicians and designated trauma facilities for care to Medicaid trauma patients. Currently, the fund is providing reimbursements at an increased percentage of the base Medicaid rate (as State Budget allows) for hospital care and physician care delivered to fee-for-service Medicaid trauma patients with an Injury Severity Score (ISS) of 9 or greater.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State WASHINGTON

9. Transfer Policy

For a hospital transferring a client to another acute care hospital, a per diem rate is paid for each medically necessary day. The per diem rate is determined by dividing the hospital's payment rate for the appropriate DRG by that DRG's average length of stay.

Except as indicated below, the payment to the transferring hospital will be the lesser of: the per diem rate multiplied by the number of medically necessary days at the hospital; or, the appropriate DRG payment.

If a client is transferred back to the original hospital and subsequently discharged, the original hospital is paid the full DRG payment. It is not paid an additional per diem as a transferring hospital. The intervening hospital is paid a per diem payment based on the method described above.

The hospital that ultimately discharges the client is reimbursed the full DRG payment; however, if a transfer case qualifies as a high or low cost outlier, the outlier payment methodology is applied.

10. Readmission Policy

Readmissions occurring within 7 days of discharge will be reviewed to determine if the second admission was necessary or avoidable. If the second admission is determined to be unnecessary, reimbursement will be denied. If the admission was avoidable, the two admissions may be combined and a single DRG payment made. If two different DRG assignments are involved, reimbursement for the appropriate DRG will be based upon a utilization review of the case.

11. Administrative Days Policy

Administrative days are those days of hospital stay wherein an acute inpatient level of care is no longer necessary, and an appropriate non-inpatient hospital placement is not available. Administrative days are reimbursed at the statewide average Medicaid nursing home per diem rate.